



# Commonwealth of Kentucky Employee Group Life Insurance Program Enrollment/Change/Termination Form

Standard Insurance Company  
Group Policy Number: 641682-A

Please complete and print all information. Please use black or blue ink only.

SSN \_\_\_\_\_ Location Name \_\_\_\_\_  
Specify name of Agency, School Board or Health Dept.  
Name \_\_\_\_\_ Location Number \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last First MI (MM-DD-YYYY)  
Address \_\_\_\_\_ Annual Salary \_\_\_\_\_ Gender \_\_\_\_\_ M \_\_\_\_\_ F  
Street  
City County State Zip Hire Date \_\_\_\_\_ Work Number \_\_\_\_\_

## A. Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Eligible employees are insured at no cost to the employee for the Basic Life and AD&D Insurance  
ALL ELIGIBLE EMPLOYEES \$20,000 Cost: \$1.96 (employer paid)

## B. Optional Life and Accidental Death and Dismemberment (AD&D) Insurance (Select One Plan)

I wish to \_\_\_\_\_ enroll\* in, \_\_\_\_\_ change\* to, \_\_\_\_\_ terminate the optional insurance plan checked:

Plan 1 \_\_\_\_\_ \$ 5,000

Plan 2 \_\_\_\_\_ \$10,000

Plan 3 \_\_\_\_\_ One times annual salary\*\*

Plan 4 \_\_\_\_\_ Two times annual salary\*\*

	AGE BAND	RATE PER \$1,000
MONTHLY CONTRIBUTION =	Under 40	0.21
	40 - 59	0.50
	60 and over	0.80

\*Evidence of Insurability may be required depending on the circumstances and/or for Insurance over \$150,000.

\*\*Under plans 3 and 4, Insurance amounts will be rounded to the nearest multiple of \$1,000. Amounts of insurance do not automatically increase with a salary change.

## C. Dependents Life Insurance (Select One Plan)

Please \_\_\_\_\_ enroll\* my dependents in, \_\_\_\_\_ change\* my present plan to, or \_\_\_\_\_ terminate the plan checked below:

	Plan A	Plan B	Plan C	Plan D	Plan E
Spouse	\$10,000	\$5,000	\$5,000	\$10,000	--
Dependent Children to 6 mos.	\$ 2,500	\$1,500	--	--	\$2,500
6 months to 18 years**	\$ 5,000	\$3,000	--	--	\$5,000
MONTHLY CONTRIBUTION =	\$10.00	\$5.35	\$2.25	\$7.90	\$3.25

\*Evidence of Insurability may be required depending on the circumstances.

\*\*18 and older if attending an educational institution and relying on the employee for financial support.

## D. Waiver of Optional Life and Dependents Coverage

☐ I certify that I have been given the opportunity to enroll myself and my eligible dependents in the above coverage. I have declined the Optional and/or Dependents Life coverage and understand that it will be necessary for me and my dependents to furnish evidence of insurability if I desire any of the above coverage in the future (other than during an open enrollment period or other exception detailed in the certificate booklet).

## E. Employee Signature and Date (Required)

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

### To Be Completed by the Insurance Coordinator

IC Signature \_\_\_\_\_ Date \_\_\_\_\_

Effective Date for: \_\_\_\_\_ Enrollment \_\_\_\_\_ Change \_\_\_\_\_ Termination

Basic Insurance \_\_\_\_\_

Optional Insurance \_\_\_\_\_

Dependents Group Term Life \_\_\_\_\_

### In case of change or termination:

Employment Termination Date \_\_\_\_\_

OR

Date of Qualifying Event \_\_\_\_\_

Description of Qualifying Event \_\_\_\_\_

Send **PERSONNEL CABINET COPY** TO:

Personnel Cabinet  
Group Life Insurance Administration  
200 Fair Oaks Lane, Room 503  
Frankfort, KY 40601

PERSONNEL COPY